NBFSA
Pharmacy Benefits Management

PRIOR AUTHORIZATION/QUANTITY LIMIT EXCEPTION CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	PRESCRIBER TAX ID

CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX

PRESCRIBER ADDRESS	CITY	STATE	ZIP

PATIENT NAME	MEMBER ID NUMBER	DATE OF BIRTH	GENDER
			M F

Please complete the following: **Dx Code**: _____

Drug Name:_____ Strength: _____

Dosage Form: _____ Quantity Requested: _____

1. Is the request for the generic version of the drug requested above? ..... ☐ Yes ☐ No
2. Has the patient taken the medication in the past 180 days? ..... ☐ Yes ☐ No
3. Please list any medications the member has tried and failed for this diagnosis *(omission of information indicates N/A or none)*:

_____

_____

4. Please list any medications the member has a contraindication or is intolerant to for this diagnosis *(omission of information indicates N/A or none):*

_____

_____

5. Please provide clinical rationale for requested drug (attach any medical record documentation of laboratory results or other supporting medical documentation):_____

_____

_____

_____

PLEASE NOTE: If you are prescribing more than the program quantity limit, please complete and sign page 2.

Please certify the following by signing and dating below: I understand that I am requesting restricted access drug on a NBFSA formulary or exception for drug excluded from a NBFSA formulary. I certify that the above-referenced patient has previously used the medications as noted above and such drugs were detrimental to the patient's health or were ineffective in treating the patient's condition and, in my opinion, are likely to be detrimental to the patient's health or ineffective in treating the condition again. I further certify that my patient's medical records accurately reflect the information provided. I understand that NBFSA, LLC may request medical records for this patient at any time in order to verify this information. I further understand that if NBFSA, LLC determines this information is not reflected in my patient's medical records, NBFSA, LLC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature _____ Date: _____

For NBFSA, LLC members, fax form to 336-760-2664

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PATIENT NAME	Member ID	DATE OF BIRTH	GENDER
			M F

Please answer the following: Diagnosis Code:_____

Medication Requested:_____

Requested Quantity:_____ per ☐ day ☐ 5 days ☐ 28 days ☐ 30 days

Dosage Requested:_____

****Please enter quantity as a numeric value with one decimal place (ex. 1.0, 1.5)****

In the space provided, please document support for the requested Quantity Limit Exception (this may include documented clinical rationale and/or medical records). **Rationale must be provided.**

_____

_____

_____

_____

_____

_____

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that NBFSA, LLC may request medical records for this patient at any time in order to verify this information. I further understand that if NBFSA, LLC determines this information is not reflected in my patient's medical records, NBFSA, LLC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required):_____ **Date**:_____

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